

(STA-452) STATON CORRECTIONAL FAC

[illegible]

RX: 7247643 BANERJEE, M.D. (MIM), SREELEKHA  
START - 04/14/2005 STOP - 07/12/2005

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
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**NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDES**

CHARTING FOR 05/01/2005 THROUGH 05/31/2005

Physician	BANERJEE, M. D. (MBB), SREELEKHA	Telephone No.	Medical Record No.
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Alt. Physician	Alt. Telephone
----------------	----------------

HALOPERIDOL & DERIV	Rehabilitative
---------------------	----------------

ergies	Renal/Reproductive Potential
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## Diagnosis

Medicaid Number	Medicare Number	Complete Entries Checked:
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11-17-25

By: <i>A. [Signature]</i>		Title: <i>AN</i>		Date: <i>7-2-91</i>	
PATIENT		PATIENT CODE		ROOM NO	
				BED FACILIT	

NAME	UNIT	GRADE	REPORT CODE	ACCOUNTS	EXP	THREAT
CHAD, JERRY			140977	1		

[illegible]



2072

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29								
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																																						
CHARTING FOR <i>6/1/01</i>															THROUGH <i>6/3/01</i>																							
Physician <i>Sommier</i>															Telephone No.														Medical Record No.									
Alt Physician <i>Banerjee</i>															Alt. Telephone														<i>14097</i>									
Allergies <i>Haidol</i>															Rehabilitative Potential																							

Diagnosis				
Medicaid Number	Medicare Number	Complete Entries Checked		
By: <i>A. Stewart</i>		Title: <i>Jan</i>	Date: <i>6/8/10</i>	
PATIENT <i>Doned, Jeffery</i>	PATIENT CODE	ROOM NO.	BED	FACILITY
				<i>ST</i>



**MEDICATION ADMINISTRATION RECORD**

06/01/2004

New York (STA-452) STATION CORRECTIONAL FAC

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
DUOXETINE (PROZAC) 20MG CAP																														
TAKE 1 CAPSULE(S) BY MOUTH EVERY MORNING																														
RX: 5601924 BANERJEE, M.D. (MHN), SREELEKHA																														
START - 05/08/2004 STOP - 06/01/2004																														
HYDROXYZINE (PATARIL) 25MG CAP																														
TAKE 1 CAPSULE(S) BY MOUTH AT BEDTIME																														
RX: 5601931 BANERJEE, M.D. (MHN), SREELEKHA																														
START - 05/08/2004 STOP - 06/01/2004																														
Zantac 150mg BID X 90 (days)																														
5/28/04 → 8/28/04																														

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29				
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																																		
CHARTING FOR 06/01/2004 THROUGH 06/30/2004																																		
Physician BANERJEE, M.D. (MHN), SREELEKHA															Telephone No.										Medical Record No.									
Alt. Physician															Alt. Telephone																			
Allergies HALOPERIDOL & DERIV															Rehabilitative Potential																			
Diagnosis																																		
Medicaid Number										Medicare Number										Complete/Entries Checked														
By: [Signature]										Title: LPN										Date: 5/31/04														
PATIENT GOULD, JEFFERY															PATIENT CODE 140977										ROOM NO 1					BED FACILITY ST				



# MEDICATION ADMINISTRATION RECORD

05/01/2004

(STA-432) STATION CORRECTIONAL FAC

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	
<b>ANITIDINE (ZANTAC) 150MG TAB</b> TAKE 1 TABLET(S) BY MOUTH TWICE DAILY AS NEEDED RX: 5282106 MCARTHUR, P. A., DONALD, PA START - 02/28/2004 STOP - 05/27/2004	6A																														
<b>FLUOXETINE (PROZAC) 20MG CAP</b> TAKE 1 CAPSULE(S) BY MOUTH IN THE MORNING RX: 5333532 BANERJEE, M.D. (MFM), SREELEKHA START - 03/11/2004 STOP - 05/09/2004	6A																														
<b>HYDROXYZINE-PAM (VISTARIL) 25MG CAP</b> TAKE 1 CAPSULE(S) BY MOUTH AT BEDTIME RX: 5333540 BANERJEE, M.D. (MFM), SREELEKHA START - 03/11/2004 STOP - 05/09/2004	6P																														
<b>Prozac 20mg 1 cap</b> <b>P.O. q AM</b> <b>5/4/04 - 6/6/04</b>	6A																														
<b>Vistaril 25mg P.O.</b> <b>qhs x 30 days</b> <b>5/6/04 - 6/6/04</b>	6P																														
<b>Zantac 150mg 1 tab</b> <b>bid x 90 days</b> <b>5/28/04 8/28/04</b>	6A 6P																														

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR	05/01/2004	THROUGH	05/31/2004
Physician	BANERJEE, M.D. (MFM), SREELEKHA		Telephone No.
Alt. Physician			Alt. Telephone
Medications	HALOPERIDOL & DERIV		Rehabilitative Potential
Diagnosis			
Medicaid Number	Medicare Number	Complete Entries Checked	
PATIENT	GOULD, JEFFERY		By: <i>B. B. S. S.</i>
PATIENT CODE	140977	ROOM NO.	1
BED	FACILITY		STI



## MEDICATION ADMINISTRATION RECORD

04/01/2004

STD101

(STA-452) STATION CORRECTIONAL FAC

MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
RANITIDINE (ZANTAC) 150MG TAB																													
TAKE 1 TABLET(S) BY MOUTH TWICE DAILY AS NEEDED		UA																											
RX: 5282106 MCARTHUR, P.A., DONALD, PA		LP																											
START - 02/28/2004 STOP - 05/27/2004																													
FLUOXETINE (PROZAC) 20MG CAP																													
TAKE 1 CAPSULE(S) BY MOUTH IN THE MORNING		UA																											
RX: 5333532 BANERJEE, M.D. (MHN), SREELEKHA																													
START - 03/11/2004 STOP - 05/09/2004																													
HYDROXYZINE-PAM (VISTARIL) 25MG CAP																													
TAKE 1 CAPSULE(S) BY MOUTH AT BEDTIME		LP																											
RX: 5333540 BANERJEE, M.D. (MHN), SREELEKHA																													
START - 03/11/2004 STOP - 05/09/2004																													
Naprosyn 375mg ÷ PO bid		UA																											
x 14 d		LP																											
3/23/04 - 4/6/04																													

MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
CHARTING FOR		04/01/2004																													
Physician		BANERJEE, M.D. (MHN), SREELEKHA																													
Alt. Physician																															
Allergies		HALOPERIDOL & DERIV																													
Diagnosis																															
Medicaid Number																															
Medicare Number																															
PATIENT		GOULD, JEFFERY																													
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE		04/30/2004																													
Telephone No.																															
Alt Telephone																															
Rehabilitative Potential																															
Medical Record No.																															
Complete Entries Checked		By: <i>B. Buck</i>																													
Title:																															
PATIENT CODE																															
ROOM NO.																															
BED																															
FACILITY C																															



Document 8-7

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CHARGING FOR 05/01/03		THROUGH 05/01/03		NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE	
Physician <i>Summer</i>		Telephone No.		Inmate No	
Alt. Physician		Alt Telephone		140977-AL2	
Allergies <i>NKA</i> <i>Hx 2 dxp</i>		Rehabilitative Potential			
Diagnosis					
Medicaid Number		Medicare Number		Complete Entries Checked	
PATIENT		By: <i>[Signature]</i>		Title: <i>RW</i>	
GOULD, JEFFERY TODD		PATIENT CODE		ROOM NO.	
		140977		BED FACILITY	
				Date: 5/6/03	
				SC	



1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
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NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 3-1-03

THROUGH 3-31-23

Physician S. Miller

Telephone Number

Inmate No
-----------

Alt. Physician

Alt. Telephone

140977

Allergies HxMdx

## Rehabilitative Potential

Medicaid Number

Medicare Number

Complete Entries Checked

By:

**Title**

Date:

PATIENT GOULD JEFFREY

PATIENT CODE  
140977

ROOM NO

BE

FACILITY CODE  
500



VC Document  
**Naphcare**

## MEDICATIONS

## HOUR

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 241103

THROUGH 4/30/03

Physician \_\_\_\_\_  
Alt. Physician Ms Helmo CRNP  
Allergies \_\_\_\_\_

Telephone Number

Alt. Telephone

Inmate No  
1405

### Rehabilitative Potential

Medicaid Number

Medicare Number

Complete Entries Checked

By:

Complete Entries Checked

Bernell

Title

PATIENT CODE

ROOM

PATIENT Douglas, Jefferay

PATIENT CODE  
140977



EF-WC Document 8-7

Filed 03/02/2006

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[illegible]

CHARTING FOR		NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE	
Physician	11/1/02	THROUGH	11/30/02
Alt. Physician	Telephone Number		Inmate No.
Allergies	Alt. Telephone		140977
Rehabilitative Potential			
End of Chart			
Medicaid Number	Medicare Number	Complete Entries Checked	
		By: [Signature]	
PATIENT	Title:	Date:	
[Signature]	PATIENT CODE	ROOM NO.	BED
			FACILITY CODE
			57



# UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print  
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

## DEMOGRAPHICS

Site Name & Number:

Station 843

Site Phone #

(334) 567-1548

Site Fax #

(334) 567-1538

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Patient Name: (Last, First)

Gould, Jeffrey

Alias: (Last, First)

Idmate #

140977

SS Number

417-04-5135

Date: (mm/dd/yy)

8.19.05

Date of Birth: (mm/dd/yy)

11.6.63

PHS Custody Date: (mm/dd/yy)

1.1.1

Potential Release Date: (mm/dd/yy)

1.1.1

RECEIVED AUG 31 2005

Responsible party:

☒ PHS

☐ Acute Ins.

☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)

☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

Requesting Provider:

☐ Physician

☒ NP, PA

☐ Dental

MC Arthur

Facility Medical Director Signature and Date:

[Signature]

Service mode criteria for approval via protocol

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV)

☐ X-ray (XR)

☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS)

☐ Dialysis (DA)

☒ Routine

☐ Urgent

Estimated Date of Service (mm/dd/yy)

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy

☐ Chemotherapy

Number of Visits/Treatments:

3

☐ Other

Specialist referred to:

Dr. Jackson

Type of Consultation: (See back of form for details)

Diagnosis:

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/Injury/Symptoms with Date of Onset:

Cirrhosis/+ HepC  
A-N/V + leg edema over  
past 6 months  
HT + CA<sup>+</sup> abn values  
Total Bilirubin 3.2 from 1.4

Results of a complete directed physical examination:

over 6 months  
Serum Albumin ↓ from 3.1 to 2.7  
over 6 months

Liver edge 3-4cm ↓ ribs.  
RUQ TTP scler. ? Icterus.

Previous treatment and response (including medications):

HGIZ, Lasix, Ted bases  
HT Zantac, Activity  
restriction.

\*\*\*For security and safety, please do not inform patient of possible follow-up appointments\*\*\*

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☒ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Regional Medical Director Signature,  
printed name and date required:

Will Mosier, MD

☐ Office Service Recommended and Authorized

Date resubmitted:

1.1.1

Do not write below this line for Case Manager and Corporate Data Entry ONLY

Cent Type:

Med Class:

CPT code:

PHS Audit #:



UNIVERSITY OF MICHIGAN AUTHORIZATION FOR MEDICAL MANAGEMENT REFERRAL REVIEW FORM  
 This form must be Complete and Legible. You must Type or Print in the spaces provided.  
 Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

## DEMOGRAPHICS

Site Name &amp; Number:

Staton 843

Site Phone #

(334) 567-1548

Site Fax #

(334) 567-1538

Patient Name: (Last, First)

Gould, Jeffrey

Alias: (Last, First)

Inmate #

140977

SS Number

417-04-5135

Date: (mm/dd/yy)

8.19.05

Date of Birth: (mm/dd/yy)

11.6.63

PHS Custody Date: (mm/dd/yy)

Potential Release Date: (mm/dd/yy)

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

## CLINICAL DATA

Requesting Provider:

☐ Physician☒ NP, PA☐ Dental

MCArthur

Facility Medical Director Signature and Date:

J. J. Smith

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☒ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

1/1/06

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments:

☐ Other:

Specialist referred to:

Dr. Jackson

Type of Consultation, Treatment, Procedure or Surgery:

A.L. Consult

Diagnosis:

Cirrhosis/HepC

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/Injury/Symptoms with Date of Onset:

Cirrhosis/HepC  
 ↑ N/V + ↓ leg edema over  
 past 6 months  
 H<sup>+</sup> + CA<sup>+</sup> abn values  
 Total Bilirubin 3.02 from 1.64

Results of a complaint directed physical examination:

over 6 months  
 Serum Albumin ↓ from 3.01 to 2.07  
 over 6 months

Liver edge 3-4cm ↓ ribs.  
 RUQ TTP. Sclera? Icterus

Previous treatment and response (including medications):

HCIZ, Lasix, Ted bases  
 H<sup>+</sup> Zantac, Activity  
 restriction.

\*\*\*For security and safety, please do not inform patient of possible follow-up appointments\*\*\*

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.

Date resubmitted:

1/1/06

Regional Medical Director Signature,  
printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

CPT code:

UR Auth #:



**EYE SCREENING PROTOCOL  
(WHO GETS TO SEE DR BRADFORD)**

MEASURE VISUAL ACUITY (SNELLEN EYE CHART)

RIGHT EYE (OD) \_\_\_\_\_ WITH GLASSES 20/70 WITHOUT GLASSES  
LEFT EYE (OS) \_\_\_\_\_ WITH GLASSES 20/70 WITHOUT GLASSES

IF DISTANCE VISION IS 20/30 OR WORSE WITH GLASSES:  
REFER FOR EYE CLINIC

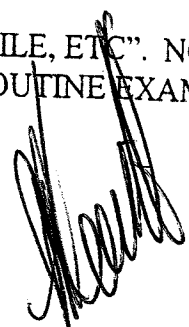
IF COMPLAINTS OF DECREASED VISION AT NEAR (READING)  
REFER FOR EYE CLINIC

IF LAST EYE EXAM GREATER THAN 2 YEARS AGO  
REFER FOR EYE CLINIC

IF COMPLAINTS OF MEDICAL NATURE (ie PAIN, HX EYE DISEASE, SUDDEN  
DECREASE IN VISION, etc.) OR REQUEST BY ANOTHER DOCTOR (ie CHRONIC  
CARE, etc.)  
REFER FOR EYE CLINIC

IF BROKEN OR LOST OR STOLEN GLASSES AND THEY WERE PRESCRIBED WITH  
PAST 18 MONTHS ORDER NEW GLASSES BASES ON LAST RX. ADVISE PATIENT  
THAT HE MUST PAY FOR GLASSES (CMS WILL BUY GLASSES ONCE EVERY 2  
YEARS ONLY.) DO NOT HAVE TO WAIT FOR NEXT EYE CLINIC.

IF ONLY COMPLAINT IS "WANTS SUNGLASSES, TINT, SHADE PROFILE, ETC". NO  
REFERRAL UNLESS ONE OF OTHER CRITERIA MET. (MAY HAVE ROUTINE EXAM  
EVERY 2 YEARS WITH NO COMPLAINT.





# INSTITUTIONAL EYE CARE

P.O. Box 390  
Lewisburg, PA 17837

(570) 523-3493  
FAX (570) 524-2817

PATIENT <u>Could, Jeffrey</u>			DATE		
NUMBER <u>7409777</u>			INSTITUTION <u>STATION</u>		
	SPHERE	CYLINDER	AXIS	PRISM	BASE
OD	-1.00				
OS	-1.75	-1.75	083		
	ADD	HEIGHT	DIST PD	NEAR PD	SEG STYLE
OD					
OS					

LENS COLOR/COATINGS			FRAME COLOR		
FRAME	STYLE		FRAME COLOR		
EYE SIZE	BRIDGE	TEMPLE	HEAT	CHEM	
DATE REC'D	DROP BALL		FINAL INSPECTION		

LENSES: \_\_\_\_\_

FRAME: \_\_\_\_\_

OVERSIZE: \_\_\_\_\_

TINT/PGX: \_\_\_\_\_

CHEM. TEMP. GLASS: \_\_\_\_\_

DIOPTERS: \_\_\_\_\_

S/H: \_\_\_\_\_

TOTAL DUE (\$): \_\_\_\_\_

## VISION SAFETY NOTICE:

• Your lenses meet or exceed American National Standard Z80.1 and FDA requirement 21 CFR Sec 801.410 for impact resistance but are not unbreakable or shatterproof. Of all the materials that lenses can be made from polycarbonate is the most impact resistant.

• If struck with sufficient force, the lenses can break into sharp pieces that can cause serious injury to the eye, or blindness. Even if the lenses do not break, the force of impact may cause the lenses or spectacle frame to contact the eye or surrounding area causing injury.

• The continued impact resistance of your lenses depends on how well you protect them from physical shocks and abuse. For your own protection, scratched or pitted lenses should be replaced immediately.

• If your occupational or recreational activities expose you to the risk of flying objects or physical impacts, your eye safety requires special safety spectacles with safety lenses, side shields, goggles and/or a full face shield.



# EYE EXAMINATION SHEET

TO: (Service Physician) <i>Bradford</i>	FROM: (Requesting Ward, Med. Fac. Phys.) <i>SCC</i>	Date of Request: <i>4/5/99</i>
Reason For Request: (Complaints and Finding)		
Past History		
Old Rx		
Signature	Type of Consult <input type="checkbox"/> Emergency <input type="checkbox"/> Routine	
<b>CONSULTATION REPORT</b>		
Subjective:    OD <i>20/50</i> OS <i>20/10</i> <i>8</i>	OPTH: <i>20 9/10/100</i>	
New Rx:    OD OS	Seg. Ht. <i>-100</i>	Ext: Date Dispensed & Initials:
Seg. Type:	<i>075 -175 x 083 / F 20</i> <i>68</i>	
IDP & Time:	<i>12/10</i> <i>54/18/148</i>	
Frame: Size: Color:	<div style="font-size: 2em; margin-bottom: 10px;"><i>[Signature]</i></div> OPTOMETRIST'S SIGNATURE	
Patients Last Name <i>Donald</i>	First <i>Jeffery</i>	Middle 
Age <i>35</i>	R/S <i>w/m</i>	ID No. <i>140977</i>



FROM : ECH LABORATORY5140723H

FAX NO. : 3345140723

Jan. 13 2006 07:51PM P3

**ELMORE COMMUNITY HOSPITAL LABORATORY**

500 HOSPITAL DRIVE

WETUMPKA, AL 36092

PH: (334)567-4311 FAX (334)514-0723

THANK YOU FOR SELECTING OUR FACILITY!

Name:	GOULD, JEFFREY			Accession:	151040	<b>STAT</b>
Patient Number:	054042			Fasting:	UNKNOWN	
Birth:	11/6/1963	Age: 42 years	Sex: M	Collected/Drawn:	1/13/2006 07:10 PM	CBN
DOCTOR:	STATON CORR FACILITY			Received in Lab:	1/13/2006 07:10 PM	APJ
Home Phone:	(000)000-0000					
HOSPITAL NO.	323717					
DR NAME	PEASANT					

Test Name	Result	Units	Flag	Reference Range
<b>CMP (Comprehensive)</b>				
				Run By: SGG on 1/13/2006 at 07:31 PM
Glucose	103	mg/dL		70 - 105
BUN	7	mg/dL		4 - 27
Creatinine	1.0	mg/dL		0.4 - 1.5
Sodium	137	mmol/L		136 - 145
Potassium	3.2	mmol/L	LOW	3.6 - 5.0
Chloride	108	mmol/L	HIGH	98 - 107
CO2	27	mmol/L		22 - 28
Calcium	8.4	mg/dL		8.4 - 10.2
Total Protein	6.3	g/dL		6.0 - 8.3
Albumin	2.6	g/dL	LOW	3.5 - 5.0
ALT	33	IU/L		10 - 40
AST	60	IU/L	HIGH	10 - 42
Alk Phos	142	IU/L	HIGH	32 - 92
Total Bil	3.5	mg/dL	HIGH	0.2 - 1.0
<b>Uric Acid</b>				
				Run By: SGG on 1/13/2006 at 07:31 PM
Uric Acid	4.8	mg/dL		2.6 - 7.2

— End Of Report —

Reviewed By: \_\_\_\_\_

Date: \_\_\_\_\_